

**AMOUNT, DURATION, AND SCOPE OF MEDICAL  
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY**

1. Inpatient hospital services other than those provided in an institution for mental diseases.

Provided with      No limitations  
  X   Limitations\*

2. a. Outpatient hospital services.

Provided with      No limitations  
  X   Limitations\*

- b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise included in the State plan).

Provided with   X   No limitations  
     Limitations\*  
Not provided     

- c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

Provided with   X   No limitations  
     Limitations\*

3. Other laboratory and x-ray services.

Provided with      No limitations  
  X   Limitations\*

4. a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Provided with      No limitations  
  X   Limitations\*

- b. Early and periodic screening, diagnostic and treatment (EPSDT) services for individuals under 21 years of age, and treatment of conditions found.\*

- c. Family planning services and supplies for individuals of child-bearing age.

Provided with      No limitations  
  X   Limitations\*

\*Description provided on attached sheet.

TN No.   94-014   Approval Date   10/27/94   Effective Date   9/1/94    
Supersedes TN No.   91-13

AMOUNT, DURATION AND SCOPE OF MEDICAL AND  
REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

5. a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

Provided with ☐ No limitations  
☒ Limitations\*

- b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided with ☒ No limitations  
☐ Limitations\*

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

- a. Podiatrists' services:

Provided with ☐ No limitations  
☐ Limitations\*  
Not provided ☒

- b. Optometrists' services.

Provided with ☐ No limitations  
☒ Limitations\*  
Not provided ☐

- c. Chiropractors' services.

Provided with ☐ No limitations  
☐ Limitations\*  
Not provided ☒

- d. Other practitioners' services.

Provided with ☐ No limitations  
☒ Limitations\*  
Not provided ☐

TN No. 99-001 Approval Date 5/24/99 Effective Date 2/12/99

Supersedes TN No. 97-14

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**AMOUNT, DURATION, AND SCOPE OF MEDICAL  
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY**

7. Home health services.

- a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Provided with      No limitations  
  X   Limitations\*

- b. Home health aide services provided by a home health agency.

Provided with      No limitations  
  X   Limitations\*

- c. Medical supplies, equipment, and appliances suitable for use in the home.

Provided with      No limitations  
  X   Limitations\*

- d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

Provided with      No limitations  
  X   Limitations\*

8. Private duty nursing services.

Provided with      No limitations  
                         Limitations\*  
Not provided   X  

9. Clinic services.

Provided with      No limitations  
  X   Limitations\*  
Not provided     

\* Description provided on attached sheet.

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TN No. 94-014 Approval Date 10/27/94 Effective Date 9/1/94  
Supersedes TN No. 92-14

**AMOUNT, DURATION, AND SCOPE OF MEDICAL AND  
REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY**

10. Dental services.

Provided with ☐ No limitations

☒ Limitations\*

Not provided ☐

11. Physical therapy and related services.

a. Physical therapy

Provided with ☐ No limitations

☒ Limitations\*

Not provided ☐

b. Occupational therapy.

Provided with ☐ No limitations

☒ Limitations\*

Not provided ☐

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

Provided with ☐ No limitations

☒ Limitations\*

Not provided ☐

\* Description provided on attached sheet.

TN No. 97-14 Approval Date 1/14/98 Effective Date 10/15/97

Supersedes TN No. 94-14

**AMOUNT, DURATION, AND SCOPE OF MEDICAL AND  
REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY**

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

Provided with ☐ No limitations  
☒ Limitations\*  
Not provided ☐

b. Dentures.

Provided with ☐ No limitations  
☐ Limitations\*  
Not provided ☒

c. Prosthetic devices.

Provided with ☐ No limitations  
☒ Limitations\*  
Not provided ☐

d. Eyeglasses.

Provided with ☐ No limitations  
☒ Limitations\*  
Not provided ☐

\* Description provided on attached sheet.

TN No. 97-014 Approval Date 1/14/98 Effective Date 10/15/97

Supersedes TN No. 94-14

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**AMOUNT, DURATION, AND SCOPE OF MEDICAL  
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY**

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

Provided with ☐ No limitations  
☒ Limitations\*  
Not provided ☐

b. Screening services.

Provided with ☐ No limitations  
☒ Limitations\*  
Not provided ☐

c. Preventive services.

Provided with ☐ No limitations  
☐ Limitations\*  
Not provided ☒

d. Rehabilitative services.

Provided with ☐ No limitations  
☒ Limitations\*  
Not provided ☐

\* Description provided on attached sheet.

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TN No. 94/014 Approval Date 10/27/94 Effective Date 9/1/94

Supersedes TN No. 91-16

**AMOUNT, DURATION, AND SCOPE OF MEDICAL  
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY**

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

Provided with      No limitations  
  X   Limitations\*  
Not provided     

b. Skilled nursing facility services.

Provided with      No limitations  
     Limitations\*  
Not provided   X  

c. Intermediate care facility services.

Provided with      No limitations  
     Limitations\*  
Not provided   X  

15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

Provided with      No limitations  
  X   Limitations\*  
Not provided     

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

Provided with      No limitations  
  X   Limitations\*  
Not provided     

16. Inpatient psychiatric facility services for individuals under 22 years of age.

Provided with      No limitations  
  X   Limitations\*  
Not provided     

\* Description provided on attached sheet.

TN No. 94/014 Approval Date 10/27/94 Effective Date 9/1/94  
Supersedes TN No. ~~85-3~~ 93-14

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**AMOUNT, DURATION, AND SCOPE OF MEDICAL  
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17. Nurse-midwife services.

Provided with   X   No limitations  
                                 Limitations\*  
Not provided       

18. Hospice care (in accordance with section 1905(o) of the Act).

Provided with        No limitations  
                                 Limitations\*  
Not provided   X  

19. Case management services as defined in, and to the group specified in, Supplement 1 to Attachment 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

Provided with        No limitations  
                            X   Limitations\*  
Not provided       

20. Extended services to pregnant women.

- a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

Provided   X   with additional coverage ++

- b. Services for any other medical conditions that may complicate pregnancy.

Provided   X   with additional coverage ++

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

\* Description provided on attached sheet.

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TN No.   94-014   Approval Date   10/29/94   Effective Date   9/1/94    
Supersedes TN No.   93-14



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**AMOUNT, DURATION, AND SCOPE OF MEDICAL  
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21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible provider (in accordance with section 1920 of the Act).

Provided with ☐ No limitations  
☐ Limitations\*  
Not provided ☒

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

Provided with ☐ No limitations  
☐ Limitations\*  
Not provided ☒

23. Certified pediatric or family nurse practitioners' services.

Provided with ☒ No limitations  
☐ Limitations\*

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

- a. Transportation.

Provided with ☐ No limitations  
☒ Limitations\*  
Not provided ☐

- b. Services of Christian Science nurses.

Provided with ☐ No limitations  
☐ Limitations\*  
Not provided ☒

\* Description provided on attached sheet.

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TN No. 94-014 Approval Date 10/27/94 Effective Date 9/1/94  
Supersedes TN No. 87-9/87-4

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**AMOUNT, DURATION, AND SCOPE OF MEDICAL  
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY**

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary. (Cont.)

- c. Care and services provided in Christian Science sanatoria.

Provided with      No limitations  
Limitations\*

Not provided   X  

- d. Nursing facility services for patients under 21 years of age.

Provided with      No limitations  
Limitations\*

Not provided   X  

- e. Emergency hospital services.

Provided with      No limitations  
Limitations\*

Not provided   X  

- f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

Provided with      No limitations  
Limitations\*

Not provided     

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

Provided      Not provided   X  

\* Description provided on attached sheet.

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TN No. 94-014 Approval Date 10/27/94 Effective Date 9/1/94  
Supersedes TN No. 87-4